CALVARY HOSPITAL
Where Life Continues

Bronx Campus:
1740 Eastchester Road, Bronx, NY 10461

Brooklyn Campus:
150 55th Street, Brooklyn, NY 11220

FINANCIAL AGREEMENT

I. **Request for Admission.** I, as the patient (the "Patient") request admission to, and/or I, as the guarantor (the "Guarantor") request that the Patient be admitted to, Calvary Hospital (the "Hospital").

II. **Guarantee of Payment.**

The Hospital will be providing hospital and medical care to the Patient. If any insurance coverage that the Patient may have (***Medicare, Medicaid, Blue Cross or other Commercial Insurance including HMO's***) either rejects the billing claim or allows only part of the claim, the Patient does not have insurance coverage, and/or the insurance coverage is exhausted during the Patient's hospitalization, I, as Patient and/or Guarantor, shall be fully responsible for payment of the Patient's hospital bill, ***with the Patient's resources***, based upon the Hospital's posted charges, which I agree are fair and reasonable, a room & board rate of **$2,050 per day *plus*** ancillary services and supplies ***plus*** *a* 9.63% *New York State Indigent Care Pool Surcharge*.

Calvary Hospital's website (www.calvaryhospital.org) can also provide additional information links for the following:

- Financial assistance policy
- Policy on viewing Calvary Hospital charges
- Insurance Plans that Calvary Hospital participates
- Physician (employed and consulting) insurance participation

III. **Cooperation in Completing Insurance Coverage Forms and Medicaid Application.** I, as Patient and/or Guarantor, have been advised of the Patient's responsibilities as specified within the Medicaid guidelines. I, as Patient and/or Guarantor, shall cooperate with the Hospital by furnishing information and by signing appropriate documents in order to apply for insurance coverage and/or Medicaid.

IV. **Understanding this Agreement.** I have read and do understand this Agreement. A copy has been provided for my retention.

Patient Name	Name of Guarantor (Print)
Signature of Patient	Signature of Guarantor
	Street Address
Witness	City, State, Zip
Date	Telephone Number

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UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

I hereby authorize and direct the above named Medical facility, having treated me to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representative thereof to examine and make copies of all records relating to care and treatment. I also authorize Calvary Hospital to bill on behalf of the above mentioned patient if the patient is no longer here at the time of the billing.

Date_____ Signature of Patient or Authorized Representative_____

I hereby assign, transfer, and set over to the above named Medical facility sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital.

Date_____ Signature of Patient or Authorized Representative_____

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given to me in applying for payment under title XVIII of the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Date_____ Signature of Patient or Authorized Representative_____

MEDICARE "60 DAYS" FORM

Medicare will pay an additional 60 days of hospital care subject to an **$838.00** daily co-insurance payment for which you are responsible. The 60 days are a lifetime maximum and once payment is made, the 60-day reserve will be permanently reduced by the days used. Do you wish to have payment under the provision for your present hospital stay?

Yes_____ No_____

Date _____ Signed _____ _____
Relationship to Patient

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MEDICARE

GENERAL EXPLANATION OF MEDICARE BENEFITS FOR 2025

PART A – DEDUCTIBLE AND CO-INSURANCE AMOUNTS

TIME LIMITATION	INPATIENT HOSPITALIZATION	PATIENT RESPONSIBILITY (or supplemental insurance if available)
First 60 days	Full Days) (Full Medicare Coverage After Deductible	**$1,676** (each benefit period)*
61st thru 90th Day	Co-insurance Days (Partial Medicare Coverage)	**$419** (per day) Always equal to ¼ of hospital deductible
91st thru 150th Day	Lifetime Reserve Days (Partial Medicare Coverage) (60 days nonrenewable)	**$838** (per day) Always equal to ½ of hospital deductible

PART B – DEDUCTIBLE AND CO-INSURANCE AMOUNTS

	PHYSICIAN'S SERVICES	
No Time Limit	Deductible	**$257** (once per year)
No Time Limit	Co-insurance (20% of "Medicare Approved Charge")	**$15** (approx.) per visit

* A "benefit period" (also called "spell of illness") is a period of consecutive days that begins with a hospitalization and ends when the patient has not been an inpatient of a hospital or a skilled nursing facility for 60 consecutive days. A beneficiary can have more than one benefit period per year.